Clinical Education Initiative
Support@ceitraining.org

PAIN MANAGEMENT FOR PEOPLE WHO USE OPIOIDS

Mariya Masyukova, MD, MS

11/16/2023

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[video transcript]

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Dr Mariya Masyukova, she received a degree with a master's in science and clinical research from the Albert Einstein College of Medicine, and completed her residency program in Family and Social medicine at Montefiore Medical Center for the next few years as faculty at Montefiore, Dr Masyukova provided primary and substance use disorder care at a federally qualified health center, worked as an embedded provider at a supportive housing site and taught in the family Medicine Residency Program at the New York City homeless health care fellowship in 2003 she became the medical director of Addiction Medicine and Drug User Health at Project renewal, and she is board certified in family medicine and addiction medicine. Thank you so much for that introduction. It's very nice to be here. I'm going to get into the material. I have no financial disclosures. I will be discussing some off label uses of medications. If I say any brand names before saying the generic names, please feel free to complain in the chat. So why are we here today? This is an issue that's very important to me and I'm sure all of you, we know that folks who experience homelessness, who use drugs, should have access to pain management. However, we also know that when seeking pain relief, folks who use drugs are often denied, labeled as drug seekers and end up receiving sub optimal and unsafe care. Folks who experience homelessness have many challenges in accessing appropriate treatment for most, most things, most health issues, but pain management specifically. And I just wanted to make a note about the language that we'll use throughout this presentation. We know that when we use stigmatized, stigmatizing language around colleagues or in documentation, safety is compromised, and patients do end up getting inappropriate care. And so I'll be using Person Centered terms and neutral terms like substance use, a person who uses opioids, a person who has alcohol use disorder. And instead of words like drug seeking behavior or drug seeker, we we just describe what's happening, which is a person who is seeking care. So as we get started, I just, I wanted to invite everyone to think about what pain is, how do and how do we know right? And you know, who gets to decide how to how to describe and how to define pain. So the way, the A simple way to think about it, is that pain is a signal. It can protect us. It can be a sign of injury and damage. We learn from pain. You know, what body part of ours is, is being hurt. We recognize that it hurts. We might have negative emotions associated with it. So it's actually a very useful learning tool at times, about dangerous things that we need to avoid. Now, you know that describes acute pain, and pain is supposed to, you know, ideally resolve after the damage has healed when acute pain doesn't resolve after healing, we call it chronic pain. There's various technical definitions about, you know, whether that means one month, three months, six months, but overall, you know, we think about tissue damage and healing as a measure of whether pain is acute or chronic. That's how we speak about it. All right, oftentimes, talking to colleagues, talking to patients, we hear about the duality of the pain experience and whether pain is real or in my head, or whether it's physical or it's emotional or mental, whether

someone's being sincere about their pain, or whether they're, you know, being quote, unquote, manipulative with their clinician. And where that duality gets us is, you know, drawing a line between people who are deserving of relief from their pain and people who don't deserve relief from their pain. And if you know, you come away with nothing else from this presentation. I just I, I would like to convey how much you know anyone who expresses pain is deserving of pain relief, whatever that means for that particular person. And the experience that is the most meaningful is the. Experience of the person with the pain that is our expert. And one thing that we need to do, and you know, a challenge for us as folks who work with clients or patients, is to get friendly with the complexity of the pain experience, to stay curious about the person's experience, to listen to them, to believe them, that in itself, can be a meaningful intervention for for chronic pain, we always consult the pain expert first, and that pain expert is the patient and the you know, the person with the pain and something very important, especially with the you know, with patients who are experiencing homelessness or who are unstably housed, is really to stay present throughout the process and to stay consistent. Okay, chronic pain is common. It affects, you know, at least 20% of people worldwide, more of us, as we get older, about half of older adults have chronic pain. It accounts for many physicians visits and medical visits. People experiencing homelessness have a an extremely high burden of chronic pain. So it's upwards of about 60% in most of the studies that I've seen with some variation. So you know, part of the intersection here is that there are multiple conditions also associated with chronic pain that unfortunately, folks experiencing homelessness are more than you know, more likely to experience so folks who live with trauma, experiences of trauma, both physical and psychological, are more likely to have chronic pain. Folks with heart and blood vessel disease, cardiovascular disease, viral hepatitis, HIV infection can on their own, cause pain and are more likely to occur and people were chronic pain is more likely to occur in people with these conditions, psychiatric illness, substance use disorders, etc. And then you know, as we we know very well also the folks that we work with often have limited resources in terms of access to health care, but also social supports, and oftentimes undergo daily wear and tear from victimization, re injury, ongoing stress, trauma, displacement, interactions with the, you know, the the criminal legal system, all of which can contribute to somebody's experience and the meaning that they make of their their chronic pain. And so folks who use non prescribed substances often do that in order to create their pain. That is, you know, usually not the only reason that that folks use substances you know, or the exclusive reason, but certainly it is. It is very common that you know, folks who use any illicit substances. About half of them are doing so to to create their chronic pain. Very common that folks who are using heroin or other opioids are doing so, at least in part, to treat pain, of course, with non prescribed analgesics, but also substances like alcohol, cannabis, cocaine, folks can, you know, do use to treat chronic pain, often effectively. And I wanted to mention also that not all substance use is a substance use disorder, and that is where, you know, one point where we have to be very clear. I'm going to get to this and the subsequent slides. We have to be very clear with ourselves and in our documentation about exactly what is going on with the person who is experiencing pain. The

numbers here vary also but anywhere from one to two thirds of patients who take medications for opioid use disorder also have chronic pain. That said, chronic pain in people with opioid use disorder, who will focus on in this presentation, is not a barrier to successful treatment for opioid use disorder and vice versa. Opioid use disorder is not a barrier to successful treatment of pain, and this has been demonstrated in studies, we can successfully treat pain in folks with opioid use disorder. The relationship between pain and opioid use disorder is very complex, and oftentimes the conditions that. Issues that contribute to the experience of chronic pain also contribute to the experience of opiate use disorder, physical problems, you know, problems with with sleep, functional you know effects increased stress, cognitive distortions, mental illness. You know, all of this kind of intersects to form the experience of these two conditions that can be mutually reinforcing as well. That said, you know, treating one So treating pain can improve someone's experience of opioid use disorder and vice versa. And that is the good news. We all we need to treat chronic pain. For somebody with opioid use disorder who's experiencing homelessness is the patient who's experiencing the pain, the clinician. So you all and whatever community resources. We can rally around, around that core team. And then, you know, there's some special sauce that each of you has, and each of you can sprinkle on, you know, on top, which is consistency and non judgments, optimism about the treatment being pragmatic, being, you know, realistic about the treatment plan, being curious, being trusting and being respectful of the patients. And there, we do not need, in most cases, anything more fancy than this list of ingredients over here, one resource that I'll share after the presentation is this guide to chronic pain management by

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Care for the Homeless by by homeless HCH clinicians network that provides a very good, extensive illustration of this, I pulled out some of the recommendations that that manuscript has, you know, for working with this population.

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This is not an extensive list of everything they recommend, but some elements of it include practicing trauma informed care, assuming trauma, especially in folks who are experiencing homelessness, especially those with who are living with pain. So we they recommend assessing and supporting folks with risky substance use and treating substance use disorders identify truly what holistic improvement looks like for each individual person, and how we know that somebody's condition is improving, and nobody can answer that without the patient themselves. Who can you know, tell us this, this is what it would mean for me to be better and for my pain to improve. They also recommend setting attainable short term goals while working with long term goals, so that there's always, you know, movement, one step at a time. There's some recommendations about appropriate medications. Sometimes that does mean full opioid agonists for people with chronic pain, and you know, being mindful of the context in which we are prescribing medications for for people to take. So supporting people if they are displaced or

medication is lost, or there's cognitive limitations that limit medication. Behavior, you know, behavior around taking medication competing priorities with, you know, having medication on them. So there's different, you know, specific strategies that we can talk about in the Q amp a to really support folks in managing their medication adherence. Non medical resources are tremendously important. So besides concrete resources, like helping someone put together a housing application and get entitlements to rallying the you know, the support of family and friends, communities of faith, and emphasizing recreation and leisure can be tremendously impactful in somebody's quality of life and their pain scores their actual experience and their feeling the way that they feel their pain, so not minimizing that. And then consistency again and again is tremendously important for for a population of patients, okay, it is extremely important to be, you know, for me as a clinician, to be very clear. Share with myself about what you know, what the patient's priorities are, and what are the diagnoses that we are trying to treat. So if there, if somebody has had pain for a long time, beyond the regular, you know, expected period of healing, I would like to know the history of that pain. I want the person to tell the story of their pain. What type of pain it might be, what it, you know, what does it feel like? Is it, you know, in the joints? Is it in their nerves? Is it a neuropathic pain? Is it a visceral pain that's less defined? I want to know all of the words that they can tell me about what it feels like. I want to check the red flags and make sure that there's nothing that you know they need emergence, workup and treatment for. I would like to know any you know, systemic conditions that we need to work on to improve their pain. And you know, really the the way to make meaning out of someone's experience, you know, of pain, is really to understand what is the effect of their pain on their quality of life. How do they perceive themselves? What is the impact of their pain on their identity and what would they be doing? How would they be functioning? If their pain was less severe? Then the second part of this is to screen, to screen, and to diagnose and to create substance use disorders, disorders and to offer evidence based treatment for substance use disorders. So again, you know, we talk about a pain history. We talk about a history of, what medications have they tried, what non medical treatments have they tried? Does it feel better to put their foot into, you know, a tub of warm water. That can be really important. Does it feel better or worse to put pressure? What, you know, what is the list of different, you know, specialists, they might have seen? What have they been told? What was their experience? So, history is hugely important. We'll talk about red flags in a in a second. And then performing as much as possible a trauma informed physical exam is hugely important here, also because we want to know, you know, sometimes, unfortunately for patients who are experiencing homelessness, they don't have access to receiving a visit, a physical exam, and so, you know, I'm not sure you know how long it's been since somebody has looked at their skin, looked at the way that their joints are moving, looked at if you know, there's any muscle atrophy anywhere in their you know, in their body, especially in where, you know, where they're having pain. And so that can be very important. I have a little illustration of a foot here to remind me that examining feet, even if the pain is not living in someone's feet is can make a huge difference. Because, you know, especially for somebody with chronic pain, because most of the folks that we might be

working with are on their feet a lot. Okay? So we make a diagnosis, you know, and we are clear with ourselves and in our documentation about the diagnosis, and we try to maintain, you know, as wide a differential as is reasonable. So, yes, this person is telling me that they are, you know, that they have arthritis in their knees. We can, you know, make that diagnosis, because most evidence points to it, but we might still maintain other, you know, possibilities that this might be a, you know, Crystal arthropathy, or, you know, something, something else that that might be going on again, to give folks, as you know, as quality access as possible to, you know, receiving treatment for anything else that might be going on. All right, so the the most important thing, I think you know, for prescribers and for non prescribers is to stay curious. Stay present again. I'm a broken record. Stay consistent with our patients and beware of bias. We know that misdiagnoses of serious conditions and under treated pain are more common for folks experiencing homelessness. Of course, people of color when. Men, people with marginalized gender identities, so trans folks, gender non conforming folks, people with non heterosexual sexual orientations, people with mental illness do not get appropriate treatment for pain a lot of the time. People who are fat and are living in bigger bodies do not get treated for pain, as well as people who are living in smaller bodies, who do not identify as fat, people who use drugs, often labeled as, you know, seeking medications or seeking drugs, and their pain isn't taken seriously. So I am imploring both the prescribers and the non prescribers to to take folks seriously, and then people with limited English proficiency, who are speaking a difference, you know, who are more comfortable speaking a different language, often do not get correct diagnoses and do not get appropriate treatment for their pain. So I try to keep in mind, you know, when my own biases might be standing in the way of, you know, really paying attention and being present for somebody and making sure that I am open to the story that they're telling me about, about pain. Okay, I'm not going to go in detail through this slide. I will keep it here for reference. The slides will be sent out. There are red flags that we try to watch out for that indicate an emergency condition that needs to be worked up and dealt with immediately before permanent damage occurs. So things like urinary retention or incontinence, saddle anesthesia, all of these things that the healthcare providers among us, you know, learn about in school, very important to to keep in mind, all right, and how do we measure how much people's pain interferes with their life? There's different kinds of answers to this. There are pretty useful scales that we can use and questions that we can ask to, you know, to really talk about pain interference. So one of the abbreviated scales is the peg score, or the peg scale, the pain enjoyment and general activity scale. This can be used if we want something sort of pseudo quantitative, you know, to mark down and to track someone's progress and the peg score has three items that include what number best describes your pain on average in the past week, zero, being no pain at all, 10, being pain as bad as you can imagine, what number would best describe how during the past week, pain has interfered With your enjoyment of life from zero to 10, and what number best describes how pain has interfered with your general activity. These, I have been really pleasantly surprised at how you know these. The words of these questions sound a little bit awkward, but most patients know exactly what I mean, and have a you know an

answer for this. And so it encourage, I would encourage you to try it. If you're interested in tracking someone's pain. If there is time and space and interest in a more comprehensive sort of description of pain interference. There's other scales available, like the brief pain inventory and the centrality of pain scale that I linked to in this presentation. Also, alright. The other diagnosis that we, you know, that we need to either make, or you know or not is the diagnosis of a substance use disorder, and specific to this talk, opioid use disorder, these are the DSM five criteria for abuse disorder that most of you have seen and use on a regular basis. You know that illustrate, you know, taking substances over a longer, a longer period of time, or larger amounts in a potentially hazardous way, where you know the risks of using a substance. Or, you know, in this case, opioids really has been outweighing the benefits for someone. What I would like to stress here is that not everybody who takes opioid agonist pain medications has an opioid use disorder. So for example, somebody who is taking oxycodone for pain and. Has been on the same dose for a while, you know, and is, you know, somebody who's who takes something like oxycodone for pain will have tolerance, so, you know, potentially less effect with greater amounts. And they, they will have withdrawal symptoms if they stop their oxycodone medication, that does not mean that they have an opioid use disorder. Tolerance and withdrawal are not sufficient criteria to diagnose and diagnose an opioid use disorder, and that is one of the points of clarity that you know is essential in working with folks with chronic pain, oftentimes, people who take opioid analgesics are labeled as having an opioid use disorder, where clinically, they actually don't. And so it is useful to go through and think about all of these criteria with someone Okay. Other screenings and assessments that could be helpful in working with somebody with a chronic pain diagnosis is psychiatric conditions and a history of traumatic brain injury that might be impacting both their pain experience and their ability to respond to different interventions and treatment options. I'm not going to go through each of these screening scales. Many of you probably have these built into your or many you know some of these built into your electronic medical record. I wanted to highlight that there are very useful tools to screen for the civilian version of post traumatic stress disorder, screen early psychosis, called the prodromal questionnaire screen, and there are screens for traumatic brain injury that is extremely common with the you know, with patients who experience homelessness, especially folks with chronic pain, that could be very useful when we work with someone to know these things, okay, harm reduction is Life Saving, and it is essential for chronic pain treatment. And the harm reduction approach is essential for many of our the folks that we work with. We need to know, you know, we're we, we need to be curious about, and ask about the quantity of somebody's substance use, their pattern of use, if they're you know, if they're using an opioid or other other substances, we should talk to them about the interactions between any medications, either that they're taking now or that we will be putting in place to address their pain conditions. Oftentimes, folks stop taking medications when they are using on days that they're using or during periods of use. And that can, you know, for people with chronic pain that can actually contribute to worsening of pain, for people with other systemic conditions like hypertension or sei disorders that can contribute to the worsening of those conditions. So it is important to

emphasize, you know, it's, you know, I know that you use on, you know, Saturday and Sunday, you can keep taking your your blood pressure medications. It's okay. It is safer to keep taking them than that. And then we can also engage patients about the medications that could interfere with and interact with the substances that they might be using. So if we're, you know, talking to someone who drinks alcohol, uses opioids, and we have just prescribed Gabapentin to help treat their pain. We can talk to them about, you know, the combination of Gabapentin with alcohol, with an opioid being more sedating, and them being at an increased risk of an overdose, if they take those things together. And, you know, oftentimes, we can actually come up with a workable plan for how to stay safe while still treating pain and not necessarily completely stopping substance use. So we're, you know, our motivational interviewing priorities and our information gathering skills intersect is asking folks about their the drugs they're using, where they're getting their supply, what the context is, what the setting is, and the pros and cons of of their use of. And how it you know, how it happens on the ground, how it happens in real life, if part of their substance use is, you know, part of the motivation to continue using substances is to get the leaf from pain. We need to get more information about that. We need to know what is effective, both prescribed and non prescribed. We need to know in what ways that it is effective, we will not most likely be able to replicate the effect of the non prescribed substance with anything that we prescribe, but it will give us a lot of information about what, what kind of relief the patient is experiencing and potentially looking for. We, you know, for folks who are using opioids, fentanyl test strips can be fentanyl test strips can be useful. Xylazine test strips are very useful for folks who who are using fentanyl, specifically for for people using non opioids, fentanyl test reps can be essential, because they might not be expecting fentanyl in their drug supply. There are super cool, fancy machines uptown, at on point where people can bring their substances and find out exactly what's in them. And then now also downtown, at Housing Works, there's there's also drug testing machines, so we can encourage folks to to use those and to learn more about why they are experiencing the effects that they are okay, recommending not using alone. Never use a loan. Hotline is up here for your reference. We can refer to overdose prevention centers, such as on point NYC, for people to use more safely. And then local harm reduction programs are on the ground giving people sterile supplies and support. And you know, connection with, you know, with resources and with community harm reduction programs are essential to our care for people with substance use and chronic pain. For this, you know, particular co morbidity and intersection, it's very important to talk about history of adverse events. Has there ever been, you know, an emergency room visit or an overdose. Has there ever been a seizure, you know? And how you know if that happens again? How do we prevent that from happening again? How do we respond to it, if that happens again? And then we can provide free Naloxone to folks, both patients and their caregivers, if you know somebody is present and also our colleagues, we need you know we need to be, to be teaching people about overdose reversal and giving them the tools to do it. Okay. We can't talk about chronic pain and opioid use disorder without talking about the broader context that you know, that our patients come from, where social inequities, and you know, and kind of generate both

generational strengths and wisdom. And, you know, historical oppression kind of factor into people's experience. We can't, you know, individually tackle that, but we need to understand that the perception of injustice actually does is associated with a worse experience of pain and worse quality of life for people with pain, we can't solve these, you know, these problems individually, however, access to, you know, helping folks access social support networks and, you know, and connect can actually mitigate some of the the effects on pain of perceived injustice. And there's been a lot of really interesting work done around this recently that I linked to here. Okay, so besides helping folks identify support systems, connecting them to interdisciplinary teams, we can also identify peer networks. Maybe you know, those peers can be other people who use drugs. Those peers could be other people with similar painful conditions, or they can be advocacy organizations, where our patients can actually derive meaning from really being around other people who are speaking out for the rights of their you know, the people who are suffering from from those conditions, and we, we need to meet reports of injustice with email. And support. Okay, I am going to skip this part because I know that some of you are here to talk about specific interventions that we can, you know, that we can use so, you know, just another plug for trying to set tangible goals with folks, something as, you know, as simple sounding as getting up in the morning. And, you know, being able to walk to the bathroom and brush your teeth can be, can feel impossible for someone with pain, and can be a huge achievement. So you know, something like that could be a small and tangible goal for patients that we're working with. Okay, skip over this as well. What are evidence based interventions for for pain treatment. I think we underestimate non pharmacological interventions for pain treatments. It has been shown that both pain and function improve for people with low back pain when there's an exercise component to their treatments, when there's massage or mindfulness interventions for neck pain, you know There, there's similar data about exercise, massage, acupuncture for you know, for for conditions like fibromyalgia, there's, you know, cognitive behavioral therapy can be hugely, hugely beneficial. And so really understanding the kind of pain that someone's experiencing and what kind of resources we can link people to, you know, can can really help somebody. Oftentimes, we think about interventions like acupuncture, you know, mindfulness as inaccessible to, you know, patients who are overall not accessing a lot of healthcare. I will say that some of the same harm reduction organizations like on point do have holistic practices on site and resources that people can access when they drop in for services. And so I would encourage us to really, you know, try to provide holistic services, where, where we practice, and if you know, for services that are not possible, to really find those low threshold opportunities for Our patients, okay, something that can make a huge difference for for patients with chronic pain, specifically, who are experiencing shelter homelessness are is our support as their, you know, clinicians for things like, you know, an extra pillow, A bed pass, you know, changing the positioning of their their bed. You know, very simple things that can you know that that seems simple, but that can make a huge difference. Okay, let's talk about medications, the most important medications we can offer to to people with opioid use disorder, whether or not they have chronic pain, are the two life saving medication options, methadone and buprenorphine.

When, if somebody chooses methadone, they do need to go to an an opiate treatment program. If somebody is requiring pain management while they're taking methadone the you know where I the first thing that I try to do is work with the opioid treatment program provider to work out a plan that is in sync with the person's methadone treatment. Buprenorphine is something that we can you know that prescribers who have a DEA license can offer there's no longer an X waiver that is required. We can offer it in primary care. We can offer it where we deliver health care to to patients. And I would encourage all of the providers you know, who prescribe to you know, to really make sure that they are counseling patients about these these medications and making buprenorphine available when it is you know, when somebody does have opioid use disorder and. Is interested in terms of non opioid medications for pain, for neuropathic pain, there is, you know, pretty good evidence for our pre Gavilan Gabapentin and atypical antidepressants and nsris, like SNRIs, like duloxetine.

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you know, folks with arthritic conditions, oftentimes, duloxetine can be helpful. And NSAIDs, non steroidal anti inflammatories, could provide some some benefit. That said, the benefit is usually small, and for most patients who are not super young, super healthy, and you know, abstinent from all other substances, there can be risks to non steroidals. And so I, I I wanted to, you know, to just emphasize that some of the medications that we do commonly use are actually not, not as evidence based, or not as safe as we sort of were might have been taught to believe. Okay, there's topical options for people that can be adjuncts for as needed pain relief. You know that can kind of take the edge off of someone's pain. Acetaminophen is my preferred go to before I go to to nonsteroidals. And we can use acetaminophen in, you know, in higher doses. And I think, you know, then over the counter labeling, so something like 1000 milligrams of acetaminophen three times a day, at least, is a, you know, an acceptable dose and regimen for somebody who doesn't have, you know, hepatitis or cirrhosis, you know, and can can metabolize the medication. Muscle relaxants are also very commonly used patients you know, will tell us if that's been helpful or not for them. There's mixed evidence about them. There's a dosing chart right here for you that will be available with the slides. I wanted to say also that there are medications that can help with pain. And if somebody has a concurrent in addition to their opioid use disorder, another substance use disorder, like alcohol use disorder, these medications can be potentially helpful and do kind of, you know, do their their job for pain relief, and they can also help with the other substance use disorder. So, for example, a medication like Gabapentin can be hugely beneficial for neuropathic pain, and it it can help with, can help prevent and treat mild withdrawal in low risk patients who you know are newly abstaining from alcohol use. There's other examples, examples here as well. Let's talk about opioids. So our review for many of us, we have our opioid agonists and our antagonists like Naloxone or

naltrexone. The antagonists turn off our receptor cause the opposite effect of an opioid or agonist causing, you know, our expected opioid effect. The partial agonist that we got is buprenorphine, and the the full agonist that we you know, that we see are, you know, the scheduled or the the non prescribed illicit substances like heroin and then the, you know, the pharmaceutical Well, agonists like our oxycodone And our pharmaceutical fentanyl. I'm flashing up the CDC recommendations here. It is important to to be aware of them. Sometimes our patients do not read the textbook and don't read these you know these recommendations and abide by them and their pain presentation, and so we don't, you know, we don't always. Have to follow all of these with with every patient, but it is important to be aware of them. Okay. It is okay to if the the benefits outweigh the risks, to give a patient with severe pain and a full opioid agonist, it is okay for somebody who's experiencing homelessness, who has opioid use disorder, to get a prescription for, for example, oxycodone, if they they require it, if consent has been obtained if we have discussed with the patient, if it is clear to you know, everyone involved that the benefits truly outweigh the risks, that we will work together to identify any problems if they occur, if we will. You know, try to make sure that storage of this medication is safe, that we monitor side effects. You know it is, it is okay for for people to receive opioid agonists. And you know, I know that it is, it can be challenging and scary in light of the, you know, the overdose rates, and you know our experience in this country of the opioid epidemic, but sometimes it is necessary, and it is beneficial to prescribe both opioid aids, and we should feel empowered to do that when necessary. The only thing that is required to prescribe, you know, by law, to prescribe full opioid agonists in terms of our you know, like specific documentation and you know, and follow up at every single visit, is checking the prescription monitoring program or I stop before prescribing a controlled substance that is in the law we, you know, we need to document that and do that to make sure that we're aware if there's another prescription for the same substance that's coming, you know, the same medication that's coming from a Different prescriber. It is not required by law for for most outpatient programs to do urine testing or to do any drug testing, for for patients, and I'm going to leave that there. We can talk about that in a little bit more once I get through the slides. It's also imperative that when we you know, if we do prescribe full agonist for folks, we talk to them about the risk of overdose. We talk to them about the risk of overdose just with the medications that we're prescribing, and if other substances are added to those medications. And we need to, you know, empower folks to make sure that, you know, they understand what resources they can use to prevent overdose and that people around them can use to reverse overdose. Okay, if challenges occur during the you know, a treatment with a controlled substance or a full agonist. We can be we can continue to be consistent, continue to be non judgmental. Realize that a lot of the challenges that specifically patients in the homeless health care sphere will exhibit actually overlap with normal reactions to, you know, the states of vulnerability and the chaos of their environment. So things like stolen medications, happens all the time, shelter missing appointments, you know, somebody got stuck somewhere. Happens all the time, feeling dysregulated. You know, change in mental status, requesting refills early, all of this we you know, before we judge someone, and

you know, document this as an aberrant behavior in their medication taking, it is sometimes very helpful to talk to that person and to try to figure out what might have happened, because whether or not somebody is on A controlled substance, this happens all the time. Okay?

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Let's

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get to my favorite part of this presentation, which is buprenorphine for chronic pain, even people who have required high doses of strong, full opioid agonists for their pain can benefit from buprenorphine, and can get pain relief with buprenorphine if they do require an an opioid for for their pain, buprenorphine is safer in a lot of ways than our full opioid agonists. It does have a ceiling effect for respiratory depression, so. You know, if somebody takes 100 milligrams of buprenorphine, they will, you know, if they are opioid experience, they will most likely not stop breathing. There's, we're understanding now that there's less of a ceiling effect for pain relief for buprenorphine. So somebody might actually require a high, you know, dose of buprenorphine to relieve their pain, and it might be very beneficial for them. And so we need to be open to this possibility also, okay, the way that we prescribe buprenorphine for chronic pain is we, sort of, we prescribe it at six to eight hour intervals, because buprenorphine effect for pain only lasts about that long. If somebody doesn't have pain and is taking buprenorphine for opioid use disorder, they can take it every 24 hours. The effect for craving suppression and for opioid use disorder, you know, lasts that long. But if somebody is trying to treat pain, the Daily Dose can be split into multiple doses. There are FDA approved formulations of buprenorphine that are, you know, that are approved for pain. There are patches and there's a Bucha formulation. I have barely seen this approved by insurance, especially Medicaid insurances. I think that might have changed. What is more common and what works. You know pretty well, especially for folks with opioid use disorder, is prescribing the buprenorphine, Naloxone formulations that are FDA approved for opioid use disorder and off label for chronic pain, even if there's no opioid use disorder that the person has been diagnosed With. Okay, this is a really handy flow chart from the Boston Medical Center, Greg and center for addiction training that you all will have access to. The other interesting thing that we can do, if somebody requires, let's say, if somebody, let's say, is taking buprenorphine for opioid use disorder and or pain and they have an, you know, a new injury, or an episode of acute pain, or worsening pain, is we can actually give somebody a full opioid agonist without stopping the buprenorphine, and allow them to have that, you know that additional pain relief, they will not experience precipitated withdrawal, if you know we do that, if they already have buprenorphine on board. Okay, I've included some resources about not having to discontinue buprenorphine when somebody is admitted to the hospital with acute pain, usually that is not necessary. And you know this is specifically for hospital based providers, and for any surgical clearance that you might be responding to for people. All right, I am going to get to the end of the presentation because I'm

really curious about if people have questions or responses or or feedback. The other additional modality that I'll mention is that medical cannabis is legal and available in New York State, and is increasingly sort of used as an intervention for our patients with chronic pain and can be effective.

53:54
Thanks so much, Maria. Let's start with the first question here, though, can you please give an example of how you converse with patients about prescribed use, use of street bought drugs, and whether they also sell their supply?

54:12
Great. Let me, is there any way that I can see that question visually? Let me click on the Q and A. It is in

54:19
the Q and A all the way at the top from our colleague, Michael. And Michael, if you are brave enough to do so, we'd love to hear from you.

54:32
All right, how do we I can't see the question, but I'm happy to try to answer it, if I can retain it in my brain, conversing with patients about prescribed taking prescribed medication, conversing with patients about Non, non prescribed use. So, for example, you know if they're not taking any, you know, prescribed medications yet or right now. Um or their pain. Take me through a typical day. You know, with your pain, what happens when you wake up? Where do you feel your pain? How? You know, how does it? How does it affect you? When is the first time you feel relief of your pain? You know, if they say that, it's after they use we talk about that, we continue moving, on through their day, so that the typical day scenario might be one way of asking about it. How frequently are you using cocaine does it provide? You know, like, what kind of relief does it provide, if at all? Or is it a distraction? Or, you know, how does your pain change? How you know, where do you feel it after you are, you know, feeling the effect of the cocaine. How do you keep yourself safe, you know. How do you know? You know. How can you tell the content of what you might be using? Is there anything, anything that you do to track your supply before you before you use? So oftentimes just kind of asking what we mean is fine.

56:07
Thanks so much. And I think Michael, we were able to switch you over so you should be able to elaborate, if you would like to

56:13

cool. Can you hear me? Yes, we can. I've been promoted. So I think in my mind, it's oftentimes on when we're out on the street roving, or when we see a patient for the first time in our safety net clinic, they, you know, I I've had instances where the first thing we talk about is their pain. It's top of mind, and we talk about, you know, the perks that they've been using. And I will often replace their supply because I know that my prescription is safer than something that they might be getting on the street. But also, and then, you know, besides kind of the obvious checking, I stop and and all of that, you know, I guess, do I? I, I feel this kind of guilt sometimes from the stigma prescribing opiates as well, because we've gone the opposite from what we used to do, you know? And so sometimes I feel uneasy about first time meeting somebody, I'm just going to replace that whole supply. And I feel like, I I trust you. I'm going to trust you, because this is, like, the relationship I want to build, and I want to continue that, and then we're going to talk about it and come up with a plan and do all that. But I think what I'm asking for is just do, is that something, you know, everybody's doing like, I want, I want a little bit of, like, you know, like, reassurance and, and then how do we responsibly talk about that? And also think about, you know, because I know a lot of my patients might sell as well. And that's, you know, what keeps you know that there, that's, that's, that's like supporting them, you know what I mean. And I want to be responsible, but also attentive to their needs. So I just wanted to see what you thought about that. Yeah,

58:13
thank you so much for that question. Thank you so much for sharing how you, you know, experience that that's awesome. I'm sure that a lot of people in the audience are, you know, struggling with the same things so and what I say is not the policy of DHS or if mount, or if Mount Sinai or CEI or, you know, I'm just speaking as myself, as a an individual, When I'm prescribing buprenorphine for opioid use disorder. I I prescribe, you know, high daily doses for most people, because they're effective, if some of those doses go out in the in the community. I know, from, you know, from both kind of documented, you know, qualitative research, and from, you know, just common sense that it is being used to help somebody who's in withdrawal or help somebody who's seeking opioid use disorder treatment. So I do not worry about diversion of buprenorphine that I prescribe. I worry. I do worry about diversion of full opioid agonists and other substances that could be, you know, contributing to someone's overdose. I am sure that those are safer than the pressed pills that folks are potentially getting. You know, in a in a non prescribed supply. The way that I frame it to patients, is I, I take a lot of sort of my own responsibility for for the framing and for the for the, you know, I, I try to assume some of, you know, some of the kind of request. And I say, Listen, I like. Being a doctor. I like being a prescriber. I don't want to lose my license. I really, you know, like it would really be a bummer. If any of this medication that has my name on it was out there, please take care of me. And this, you know, this is medication that I'm prescribing for you, for you to take. I don't know how it's gonna, you know, interact with anyone else's other medications, anyone else's health conditions. I don't know if their body will be able to, you know, fully handle it. You know, if there's

somebody who you're worried about and who needs, you know, pain relief, like, bring them in. Let me know. We'll find them here. We'll connect them like we will help them just please, you know, this is a medication that is indicated just for you, you know, and I would appreciate it as a practitioner to maintain my license if it stayed with you. And patients are usually very kind in the way that they respond to that, even if I'm not so worried about the things that I I'm saying. I'm worried about they respond really, really well to you know, like I know, of course, I want to take care of you. I want to make sure that you keep taking care of me and other patients. And yeah,

1:01:14
we have another question from Crystal. And Crystal, I see your face here, so I'm going to read your question. But if you came off mute, you can read your own question. Okay,

1:01:23
yeah, I can't see my question anymore, but I was just wondering, you know, when working with people like on the street, do you, you know, do you do any type of pain management contracts, or a combination of mat pain management, pain management contracts? Oh, I see my question now, and I'm just wondering, is there like, just to define the parameters and and just help a person understand, like, what's going on? Because, I mean, we have, like, a at Sun river health, we have pain management in clinics, and then we have, you know, providers like we we try to really outreach to as many people as we can. And I'm just wondering, with this type of work, do you do any of that?

1:02:07
Great question? Thank you. I'm not a street side provider. I see people in for primary care and Drug User Health and in a shelter based clinic and also at a residential program. So we do have some street level providers here, I'm sure, who can comment on that, if that's what you're interested in, that said contracts

1:02:28
or in both, in both, you know, just to define parameters, because sometimes people will just, there's some commonalities, people asking for, you know, additional medications or benzos or refills or lost scripts and just to try to help curtail some of the wildness that can happen. Yeah,

1:02:48
I think contracts can be useful. I don't use them routinely. I think what is, what is useful about contracts is setting expectations. And, you know, setting some boundaries. So like, listen, I will not be able to give you a an early prescription. Most likely, if you know, your prescription is lost or stolen, I just can't, I'm sorry. Like that is that we can expect. I, you know, I don't want to escalate the dose of this medication too quickly, because I'm thinking about your liver function. I'm thinking about your kidney function. So, you know, we can't expect, you know, your dose to

increase every week. You know, when I when I see you. So setting expectations verbally, if somebody has, you know, it can sort of cognitively process and incorporate that can be, I think, as you know, can be okay and doesn't require a contract. I think also, some of our patients kind of freak out when they see something that they need to sign and it's, I don't, you know, yeah,

1:03:59
I'm just thinking, like, with uniformity, if you have like, 45 providers that prescribe and to have some type of, like you were saying, level set of expectations and guidance and support, you know, especially when it comes to benzos, because a lot of our patients are asking for benzos at the same time they're Asking for opioids. And, you know,

1:04:20
I think contracts can be a useful tool if we use them as, you know, something that we reference together with patients, and ideally in perfect fantasy world, you know, as something that we actually develop together with patients. These are my pain goals. This is what we're working toward. This is the medication that I'm on. This is what I expect to get from it, you know, and referencing that contract, and being able to, you know, to look at it together and to, you know, change it if, if that's needed. So I think it can be a really

1:04:56
useful like that. Yeah, I like that, just being able to work with them together. There to develop it some more.

1:05:03
Guys, I am disappointed to be the bearer of bad news, but I'm going to cut us off here. We're a couple minutes past 4pm and I want to be aware and mindful of folks time. One shameless plug, though I'm going to put my email in the chat. CEI has an ongoing Drug User Health echo that meets once a month. This is all we do. We sit around and we talk about clients, we get feedback, we chat about complex cases. If you're interested in joining that, email me and I will get you signed up. We can go from there to others. Thank you for staying with us eight minutes past the webinar. Thank you, Dr Masyukova for another fabulous presentation. Thank

1:05:41
you so much everyone for coming. Really appreciate you being here, and thank you for all the work that you're doing. Thank You.

[End Transcript]